PRINTED: 08/28/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G133	(X2) MU A. BUII B. WIN	LDING G	ONSTRUCTION 00	(X3) DATE COMPI 07/27	LETED
	PROVIDER OR SUPPLIE			479 LE	ADDRESS, CITY, STATE, ZIP CODE XINGTON ST		
ARC OF	NORTHWEST INC	DIANA INC, THE		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ſ	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0000							
			W0	000			
	This visit was fo	or a fundamental					
	recertification a	nd state licensure survey.					
	Dates of Survey 2012.	T: July 24, 25, 26 and 27,					
	Facility number	. 000670					
	Provider number						
	AIM number: 1	.00234210					
	Surveyor:						
	1	Madical Commen					
		, Medical Surveyor					
	III/QMRP						
	The following for	ederal deficiencies also					
		lings in accordance with					
	460 IAC 9.	migs in accordance with					
	400 IAC 9.						
	Quality Review	completed on 8/3/12 by					
	1 '	•					
	1 im Snedei, Me	edical Surveyor III					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G133		ĺ	LDING	00	(X3) DATE : COMPL <b>07/27</b> /	ETED	
ARC OF	PROVIDER OR SUPPLIER	ANA INC, THE		479 LEX	ADDRESS, CITY, STATE, ZIP CODE XINGTON ST N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0130	The facility must clients. Therefor privacy during tree needs.  Based on observer facility failed for and 1 additional #3) to ensure privadministration.  Findings include  A morning observer the group home of A.M. until 7:40 A.M. until 7:	evation was conducted at on 7/24/12 from 6:10 A.M At 7:00 A.M., rofessional (DSP) #1 was stering client #3's tion in the living room and #2 stood in the living amed each of client #3's the purpose of each the other clients sat in and could hear the medical 7:10 A.M., DSP #1 was stering all of client #2's tion in the living room and #3 were present.	WO	130	The medication pass area has been moved to an area that ensures privacy for all clients. ensure future compliance, Service Coordinator will view med pass monthly for 3 month and periodically thereafter.	To	08/17/2012

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Event ID: DZYJ11

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15G133		A. BUILDING B. WING	00	COMPLETED 07/27/2012
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	479 LEX	ADDRESS, CITY, STATE, ZIP CODE XINGTON ST N POINT, IN 46307	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	medication while the other clients stood in the same room and could hear the medical information. At 7:20 A.M., DSP #1 was observed administering all of client #1's morning medication in the living room while clients #2 and #3 were present. DSP #1 named each of client #1's medications and the purpose of each medication while the other clients sat in the same room and could hear the medical information. There was no training regarding privacy observed during medication administration.  An interview with the Nurse was conducted at the facility's administrative office on 7/27/12 at 2:00 P.M The Nurse indicated all clients should have privacy during medication administration.  9-3-2(a)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) D			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		15G133	A. BUII B. WIN			07/27/2012	
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	4			ADDRESS, CITY, STATE, ZIP CODE		
400.05	NODELIMENT IND	IANIA INO TUE			XINGTON ST		
ARC OF	NORTHWEST INDI	IANA INC, THE		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
W0140	483.420(b)(1)(i)						
	CLIENT FINANC						
		establish and maintain a					
		ures a full and complete					
		ents' personal funds					
	entrusted to the	facility on behalf of clients.	1110	1.40	0		00/17/2012
			W0	140	Service Coordinator will retrain		08/17/2012
					DSPs on timely completion an accuracy of client budgeting. T		
	Based upon reco	rd review and interview,			ensure future compliance Serv		
	-	I to maintain an accurate			Coordinator will review client		
	=	m for 3 of 3 clients			budgets and accounts on a		
	U 3	roup home (clients #1, #2			bi-monthly basis and at least		
		•			monthly thereafter.		
	· · · · · · · · · · · · · · · · · · ·	m the facility managed			8/24/12 Service Coordinator w	rill	
	their funds.				retrain DSPs on timely comple		
					and accuracy of client budgeti	-	
	Findings include	:			Records will be maintained by		
					each Coordinator in specified location and all Coordinators v	.:11	
	A review of the f	facility's records was			have access.	VIII	
		facility's administrative			To ensure future compliance		
		2 at 2:15 P.M A second			Service Coordinator will review	v	
					client budgets and accounts of		
	•	t #1, #2 and #3's financial			bi-monthly basis and at least		
		e. No financial records			monthly thereafter. Behavioral		
	were available for	or review to indicate the			Health Director will review reco		
	facility kept an a	ccurate accounting			storage and retrieval methods		
	system of client	#1, #2 and #3's personal					
	finances.	-					
	An interview wit	h the Service					
	,	) was conducted at the					
	_	strative office on 7/26/12					
	at 2:30 P.M Th	ne SC indicated she did					
	not know where	the prior SC kept clients					
		personal financial records.					
		don't know where they					
		rther indicated the					
		i ilici ilidicated tile					

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	OF CORRECTION  OF CORRECTION  15G133	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SU COMPLET 07/27/20	ED		
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	STREET ADDRESS, CITY, STATE, ZIP CODE 479 LEXINGTON ST CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE (	(X5) COMPLETION DATE		
	facility managed each client's personal petty cash funds. No further documentation was available for review to indicate an accurate accounting system for client #1, #2 and #3's personal petty cash funds.  9-3-2(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			JRVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	. BUILDING 00			COMPLETED	
		15G133	B. WIN	G		07/27/2	012	
NAME OF P	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP CODE			
					XINGTON ST			
ARC OF NORTHWEST INDIANA INC, THE			_		N POINT, IN 46307			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
TAG	· ·	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	COMPLETION DATE	
W0159	PROFESSIONAI Each client's acti be integrated, co	NTAL RETARDATION L ive treatment program must pordinated and monitored by al retardation professional.	W0	159	Service Coordinator will review client goals and sign progress		08/17/2012	
	2 of 3 clients resi #2 and #3), the fa Retardation Profe to monitor clients timely revisions	tracking of program			notes monthly.  8/24/12 Service Coordinator we review client goals, monitor for progress or any changes need at least bi-monthly and sign progress notes monthly. Service Coordinator will submit progres notes to IPC monthly to file in folder.  To ensure future compliance, and Service Coordinator will jointly monitor presence of updated progress notes in IPP folders.	rill r ded ce ss IPP		
	A review of clier	nt #2's record was						
	conducted on 7/2	26/12 at 2:30 P.M The						
	Individual Suppo	ort Plan (ISP) dated						
	7/11/12 indicated	d: "Will learn to make						
	change for up to	\$5.00Will prepare a						
	dessertWill rec	tite his phone						
	numberWill se	lect correct time of						
	activities after lo	oking at modelWill						
		ne name and addresswill						
		of medication." Further						
	1	#2's record failed to						
		2's objectives were						
		e QMRP for the months						
	1		1		1			

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Event ID: DZYJ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPL		
		15G133	A. BUI B. WIN			07/27/	2012
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
ARC OF	NORTHWEST INDI	ANA INC, THE			KINGTON ST N POINT, IN 46307		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CO			
PREFIX TAG	, i	CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
	of 4/12, 5/12 and	16/12.					
	A review of clier conducted on 7/2 ISP dated 8/30/1 continue to make the name and pur Further review of to indicate client monitored by the of 4/12, 5/12 and An interview with Coordinator (QN 7/27/12 at 2:20 Particularly program monitored by the immediately enter database. No fur available for review of the conduction of the conductio	at #3's record was 26/12 at 3:15 P.M The 1 indicated: "Will 2 a side dishwill learn rpose of lisinopril." f client #3's record failed #3's objectives were 2 QMRP for the months 1 6/12.  The Service MRP) was conducted on P.M The SC indicated objectives are to be 2 QMRP monthly and ered into the computer of the documentation was few to indicate the d client #2 and #3's					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
		15G133	A. BUILDING  B. WING  07/27/2012			07/27/2012
			B. WIN		ADDRESS CITY STATE ZID CODE	
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
ADC 05		IANIA INIC. THE			XINGTON ST	
ARC OF NORTHWEST INDIANA INC, THE			CROW	N POINT, IN 46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
W0192	must focus on sk	who work with clients, training cills and competencies				
	directed toward	clients' health needs.				
	Based on observation, record review and		W0	192	The Community Service Nurse will re-train the DSP's on follow	
		cility failed for 1 of 2			medication orders. To ensure	
	-	client #1) by staff not			future compliance, the nurse w	/ill
					visit group home monthly for three months and periodically	
		tills and competency to			thereafter.	
	administer medic	cations as prescribed.			The Community Service Nurse	<u>,</u>
	Findings include	:			will re-train the DSP's on follow medication orders. This include being trained on whether or no	ving es vt
	A morning obser	vation was conducted at			medications should be taken v food.	vith
	the group home of	on 7/24/12 from 6:10			To ensure further compliance	the
	A.M. until 7:40 A	A.M At 7:20 A.M.,			nurse will visit group home to	
	client #1 received	d his morning prescribed			view medication pass monthly	for
		rect Support Professional			three months and at least	
		stered his "Naproxen 500			quarterly thereafter. Communi	
		ablet (pain)1 tablet			Services Nurse will monitor M	
					once it is returned monthly from	
	_	a dayTake with			group home. Service Coordina will ensure all staff are trained	
		ent #1 did not take his			the Arc NWI policy. Training	PO:
		food/meal. Client #1 did			Records will be submitted to S	taff
	not eat anything	during the morning			Development staff for filing.	
	observation.					
	A request for sta	ff training records was				
	-	at 1:30 P.M No				
		were submitted for the				
	_					
		d at this group home to				
		ff were trained on client				
	specific needs.					
	A second request	t for staff training records				

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G133	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	— CO!	TE SURVEY MPLETED 27/2012
	PROVIDER OR SUPPLIER  NORTHWEST INDIANA INC, THE	479 LE	ADDRESS, CITY, STATE, ZIP C XINGTON ST N POINT, IN 46307	ODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	was made on 7/27/12 at 1:45 P.M No training records were submitted for review.				
	An interview with the nurse was conducted on 7/27/12 at 2:00 P.M The nurse indicated staff should administer all medications as prescribed. The nurse further indicated staff should follow directions on medication labels on medication packets.  9-3-3(a)				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G133		X2) MULTIPLE CONSTRUCTION  A. BUILDING  D. WING  X3) DATE SURVEY  COMPLETED  07/27/2012			
NAME OF I	PROVIDER OR SUPPLIE			ADDRESS, CITY, STATE, ZIP CODE	0172172012
ARC OF	NORTHWEST IND	IANA INC, THE	CROV	VN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W0248	be made availate including staff of with the client, at the client is a mile and a staff of with the client is a mile and a staff.  Based on record facility failed to Support Plans (I clients (client #2 who worked at the program.  Findings included Client #2's record day program on Review of client most current ISF further document review to indicate were available for the clients at the Interview with describe Professice Conducted on 7/2 DSP #6 indicate ISP was not avaistaff.  A review of client with the ISP was not avaistaff.	client's individual plan must ble to all relevant staff, of other agencies who work and to the client, parents (if inor) or legal guardian.  Treview and interview, the have updated Individual SP) for 1 of 2 sampled 2), available for all staff he facility owned day  e:  The ds were reviewed at the 7/27/12 at 10:20 A.M. at #2's record indicated a P dated 7/20/11. No intation was available for the client #2's current ISPs for staff who worked with	W0248	Current ISPs for all three clier have been sent to the day program. To ensure future compliance, any time there is change in an ISP, a copy will sent to both the home and da program.  8-24-12 Current ISPs for all the clients have been sent to the program. Service Coordinator inquire about updated documentation when Day Services visits occur.  To ensure future compliance, time there is a change in an IS a copy will be sent to both the home and day program. Service Coordinator will visit home and Day Services bi-monthly to monitor.	a be y nree day r will any SP,

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  15G133		A. BUILDING B. WING	00	COMP	COMPLETED 07/27/2012	
	PROVIDER OR SUPPLIEF		479 LEX	ADDRESS, CITY, STATE, ZIP O XINGTON ST N POINT, IN 46307	CODE	
ARC OF  (X4) ID  PREFIX  TAG	summary s (EACH DEFICIEN REGULATORY OR office on 7/26/12 record indicated 7/11/12.  An interview with Coordinator (SC) 7/27/12 at 2:20 H	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) 2 at 3:30 P.M The a most current ISP dated th the Service ) was conducted on P.M The SC indicated staff should have			HOULD BE	(X5) COMPLETION DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		15G133	B. WIN			07/27/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L .			XINGTON ST		
	NORTHWEST INDI	IANA INC, THE		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
TAG W0249	REGULATORY OR  483.440(d)(1) PROGRAM IMP As soon as the informulated a clie each client must treatment prograinterventions and number and freq achievement of trindividual progra  Based on observating interview, the fact written objective opportunity for 2 the group home of the grou	LEMENTATION Interdisciplinary team has int's individual program plan, receive a continuous active im consisting of needed diservices in sufficient uency to support the the objectives identified in the implan.  Action, record review, and cility failed to implement is during times of district of 3 clients residing at (clients #2 and #3).  Evation was conducted at for 7/24/12 from 6:10  A.M At 7:10 A.M., professional (DSP) #1  Ent #2's morning int did not identify the 6 district.  Evation was conducted at for 7/24/12 from 5:10  P.M From 5:10 P.M. client #2 sat at the dining interdisciplinary team in the district interdisciplinary team has individual program plan, receive a continuous active in consistency and interdisciplinary team has individual program plan, receive a continuous active in consistency active in consistency in the district interdisciplinary team in the continuous active in consistency active in consistency in the district interdisciplinary team in the consistency in the district interdisciplinary team in the continuous active in consistency in the district interdisciplinary team in the continuous active in consistency in continuous active in continu	W0	TAG	The Service Coordinator will retrain DSPs on implementatio of objectives and document training. To ensure future compliance, the Service Coordinator will observe implementation of the program objectives at least monthly for three months and periodically thereafter.  8/24/12 The Service Coordination will retrain DSPs on implementation of objectives at document training.  To ensure future compliance, service Coordinator will obsert implementation of the program objectives at Day Services and Group Home bi-monthly.	on tor and the ve	DATE  08/17/2012
	table with no act  A facility owned	day program observation					

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, ,		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	ILDING	00	COMPLETED	
15G133			B. WIN			07/27/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
ARC OF NORTHWEST INDIANA INC, THE					KINGTON ST N POINT, IN 46307	
		·			N POINT, IN 40307	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5)
TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
		n 7/27/12 from 10:00				
		A.M During the entire				
		nt #3 walked around the				
		o activity or work.				
	, verilling with it	o would by or worth				
	A review of clier	nt #2's record was				
		26/12 at 2:00 P.M				
		dividual Support Plan				
		/12 indicated: "Will learn				
	` ′	for upto \$5.00Will				
	prepare a dessertWill recite his phone numberWill select correct time of					
	activities after looking at modelWill recite group home name and addresswill identify 6 rights of medication."					
	A review of clien	nt #3's record was				
	conducted on 7/2	26/12 at 2:30 P.M				
	Review of his In	dividual Support Plan				
	(ISP) dated 7/12/12 indicated he was to					
	participate in doi	ing work while at the day				
	program.					
	The Service Coordinator (SC) was interviewed on 7/27/12 at 2:20 P.M The					
SC stated client objectives should be implemented "during times of opportunity." The SC further indicated						
	clients #2 and #3 should have been					
	provided with me	•				
		ies during the observation				
	periods.					
	9-3-4(a)					

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	OF CORRECTION	IDENTIFICATION NUMBER:  15G133	(X2) MULTIPLE CC A. BUILDING B. WING	00				
NAME OF PROVIDER OR SUPPLIER  ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 479 LEXINGTON ST CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION SCROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  15G133		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 07/27/2012		
NAME OF PROVIDER OR SUPPLIER  ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE  479 LEXINGTON ST  CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W0252	criteria specified plan objectives r measurable term  Based on record facility failed for (client #2) to rec on individual con Findings include  A review of clien conducted at the program on 7/27  A review of clien indicated: "Tellinumber." Further record indicated attempted/compl 7/20/12, 7/23/12 7/26/12.  An interview with Support Professi conducted on 7/2 DSP #7 indicated should be impler	review and interview, the of 1 of 2 sampled clients ord accurate data based impleted goals.  In #2's record was facility owned day /12 at 10:20 A.M  In #2's program goals ing timeRecite phone for review of client #2's no documentation of eted goals on 7/19/12, 7/24/12, 7/25/12 and in the day program Direct for al (DSP) #7 was 27/12 at 11:20 A.M in the day program Direct for al (DSP) #7 was 27/12 at 11:20 A.M in the deach client's goals mented daily and staff is on each individual goal	W0	252	Staff will be re-trained on documenting goal progress. Tensure future compliance, Service Coordinator will review day program data monthly. 8/24 Staff will be re-trained on documenting goal progress. Service Coordinator will review Day Services data when Day Services visits occur to monitor for completion.  To ensure future compliance, Service Coordinator will review day program data at least bi-monthly.	v v	08/17/2012

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Event ID: DZYJ11

Facility ID: 000670

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	OF CORRECTION  OF CORRECTION  15G133	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	07/27	ESURVEY LETED 7/2012		
NAME OF PROVIDER OR SUPPLIER  ARC OF NORTHWEST INDIANA INC, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 479 LEXINGTON ST CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE		
	An interview with the Service Coordinator (SC) was conducted at the facility's administrative office on 7/27/12 at 2:20 P.M The SC indicated direct care staff should document the clients' goals daily or as written.  9-3-4(a)						

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Event ID: DZYJ11

Facility ID: 000670

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PRINTED: 08/28/2012 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED		
	15G133	B. WING		07/27/2012		
		STREET	ADDRESS, CITY, STATE, ZIP CODE	•		
NAME OF I	PROVIDER OR SUPPLIER		XINGTON ST			
ARC OF	NORTHWEST INDIANA INC, THE	CROWN POINT, IN 46307				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
TAG W0440	REGULATORY OR LSC IDENTIFYING INFORMATION)  483.470(i)(1)  EVACUATION DRILLS  The facility must hold evacuation drills at least quarterly for each shift of personnel.  Based on record review and interview, the facility failed to conduct evacuation drills during the daytime shift (7:00 A.M. to 3:00 P.M.) during the fourth quarter (October 1st through December 31st) of 2011 which effected 3 of 3 clients living in the facility (clients #1, #2 and #3.)  Findings include:  The facility's records were reviewed on 7/24/12 at 4:25 P.M The review failed to indicate the facility held an evacuation drill for clients #1, #2 and #3 on the daytime shift during the fourth quarter (October 1st through December 31st) of 2011.  The Area Manager (AM) was interviewed on 7/27/12 at 2:45 P.M The AM indicated evacuation drills are to be run during each quarter for each shift. The AM further indicated there was no documentation available for review to indicate a drill was conducted for the mentioned shift/quarter.	W0440	The Area Manager will retrain staff on evacuation drills to ensure that fire drills are ran during each shift on a quarter basis and recorded respective. To ensure future compliance, Area Manager will monitor fire drill logs monthly and thereaft.	08/17/2012  by ely. the		
	9-3-7(a)					

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PRINTED: 08/28/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  15G133	(X2) MULTIPLE CC A. BUILDING B. WING	00				
NAME OF PROVIDER OR SUPPLIER  ARC OF NORTHWEST INDIANA INC, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 479 LEXINGTON ST CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION SCROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		

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